A truth check on the closing of the LRC psychiatric rehabilitation program

Many family members and state senators have received responses to their enquiries about the closing of the LRC psychiatric rehabilitation program, from NDHHS and the governor. Sadly, some of these responses have been contradictory, misleading, and even dishonest. Here is some truth about the decisions behind the closing:

1. LB1083 did NOT envision closing psychiatric rehabilitation programs. Nebraska was over-invested in custodial and acute "treatment as usual" in the regional centers, not in psychiatric rehabilitation. As many other states have discovered, even the best community-based services cannot eliminate the need for longer-term treatment in secure settings, and state hospitals are historically the most cost-effective settings for this. LB1083 did anticipate that acute, short-term inpatient care should be provided in local community hospitals, eliminating the need for that in the regional centers. Nevertheless, longer-term beds for rehabilitation are being eliminated while short-term acute care beds are being preserved.

2. Eliminating psychiatric rehabilitation in the regional centers is NOT a "natural step" in mental health reform. It is the opposite. Fewer total beds in the regional centers mean we must use the most effective approach for those remaining beds, and that is psychiatric rehabilitation. Two thirds of the sex offenders in the regional centers have major mental illness. All the patients in the forensic units have major mental illness. Many patients will languish in the "short term" units because they remain too dangerous to discharge, or will become stuck in the "revolving door." All these patients need psychiatric rehabilitation but will not be getting it.

3. Community services will NOT provide secure settings for psychiatric rehabilitation. We have had psychiatric rehabilitation programs in the community for over 10 years. LRC provided a secure setting for people too dangerous to be in the community so they could get rehabilitation too. There are legitimate concerns about treating dangerous people in locked units in the community. There are also serious cost problems. Saying that "we don't need rehabilitation in the regional centers because the regional centers treat only dangerous people" makes no sense. The "dangerous" people who will remain in the regional centers need rehabilitation at least as much as anyone else.

4. It is NOT true that there were only 17 psychiatric rehabilitation beds at LRC. There have been 40 rehabilitation beds at LRC since 1990. In 2005 LRC administration attempted to expand rehabilitation to 80 beds. The 40-bed unit was temporarily reduced to 17 beds to accommodate extensive repairs in the original building. The expansion was unsuccessful, mainly because it was strongly resisted by LRC nursing administrators, middle managers and some psychiatrists (this often happens with mental health reform, when there is insufficient political and administrative support). When the expansion failed, the original building was not returned to a 40-bed unit, providing a convenient cover for the claim that "only" 17 beds are being closed.

5. It is NOT true that patients will receive the same treatment in other regional center units after being transferred from the rehabilitation program. Psychiatric rehabilitation is a highly specific, objectively defined approach. The differences between rehabilitation and "treatment as usual" are stark. If LRC administration believed there was no difference, they would not have attempted to expand rehabilitation at LRC in 2005.

6. The truth is that the cost-effectiveness, accountability and transparency brought by psychiatric rehabilitation and other modern approaches are a serious threat to entrenched interests that have historically controlled the regional centers, and those interests have the governor's ear right now. These are the only interests that are "welcoming" the closing of the LRC rehabilitation program.